PROTOCOL FOR THESIS

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HINDI ADAPTATION AND VALIDATION OF DIFFICULTIES IN EMOTION REGULATION SCALE 16 (DERS-16) AND PARENT FORM (DERS-P) ON INDIAN ADOLESCENTS

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State of Art

One essential component of societal adaptation is the capacity to control one's emotions. It is characterized by the ability to change emotional experiences and the ensuing behaviour in order to better adapt to a given circumstance. Maintaining mental health requires being able to handle stressful situations and respond to them in a way that makes sense. In actuality, the literature links problems with emotion regulation (ER) to a number of mental health conditions, including substance abuse, mood disorders, anxiety, personality disorders, and autism spectrum disorders. Problems with emotion regulation have also been linked to other medical conditions, such as obesity and cardiovascular disease (Gross, 2014; Jentsch & Wolf, 2020; Segura-Serralta et al., 2019).

Emotion Regulation as a concept involves Intrinsic and Extrinsic processes that entails monitoring, evaluating, and modulating one’s emotional reaction to respond to one’s goal (Thompsomn 1994). It is defined as the capacity of an individual to control three factors: (1) the rate and degree at which an emotion manifests physiologically, experientially, and behaviorally; (2) the intensity of the physiological expression of an emotion; and (3) the rate and degree at which an emotion manifests physiologically, experientially, and behaviorally in a way that is consistent with an optimal level of functioning (Bunford, Evans, & Wymbs, 2015, p. 188).Emotion Regulation in itself speaks of functional capability of emotion to motivate one person as well as inform about the environment that in turn facilitates the contextual demands(Izard and Akerman 2000).When these system falter offshoots the negative outcomes. About 75% of the mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) have been found to be associated with emotional dysregulation in the field of conceptualizing mental disorders (American Psychological Association [APA], 1994; Gross and Zaziieri, 2014; Kring and Werner, 2004). Conversely, the most significant process in the phenomenology of emotional disorders is emotional dysregulation, which has been identified in several epidemiological research as the most common (Cía et al., 2018; Kessler et al., 2012).

Accordingly, Gratz and Roemer (2004) offered a multifaceted viewpoint on ER based on empirical research, outlining six elements, or dimensions, of ER: Acknowledging one's emotional state; b. pursuing goals while feeling negative emotions; c. resisting the need to act impulsively when feeling negative emotions; d. being aware of one's emotional state; e. having access to techniques to control emotions; f. being clear about one's emotional experience.

Emotion regulation is defined by Gratz and Roemer's (2004) model as a person's perceived capacity to comprehend, recognise, react to, accept, and control their emotions. The 36 components in Gratz and Roemer's model represented six domains of emotion control abilities.

Several studies have looked at the DERS's factor structure, test-retest reliability, internal consistency, predictive validity, and validity in different clinical populations, such as adults with anxiety disorder and emotion disorder diagnoses (Bardeen et al., 2012; Fowler et al., 2014; Hallion et al., 2018; Neumann et al., 2010; Osborne et al.,2017; Perez et al., 2012). Most of these studies have focused on the DERS. Despite having a 6-factor structure at first, the DERS's factor structure has now been examined again and has shown mixed support (Hallion et al., 2018). Numerous studies (Neumann et al.,2010; Perez et al., 2012) showed that the 6-factor framework fit the data adequately. Comparatively, a number of research discovered that the model's Awareness subscale had poor validity or reliability (Fowler et al., 2014; Osborne et al., 2017). High DERS scores have been linked to clinically relevant behaviours and psychopathology symptoms, despite conflicting research regarding the DERS's five- or six-factor structure. The Awareness subscale is the one exception to this general pattern of findings, as the DERS has consistently demonstrated its validity in measuring significant difficulties in emotion regulation in people with high levels of psychopathology. (Dvorak et al., 2014; Hallion et al., 2018; Neumann et al., 2010; Roemer et al., 2009; Sloan et al., 2017; Tolin et al., 2018).

For example, a brief search conducted in September 2021 on Scopus showed that Gratz and Roemer's 2004 original publication had more than 3553 citations. Many modifications to the original scale were later proposed in an effort to increase its applicability and usefulness. Three distinct short-forms have been independently derived from the original DERS, in addition to the self-report form: the DERS-16 (Bjureberg et al., 2016), the DERS-SF (Kaufman et al.,2016), and the DERS-18 (Victor & Klonsky,2016). These three quick assessments were created in 2016 separately, albeit coincidentally. The 16-item short form known as the DERS-16 (Bjureberg et al., 2016) consists of the items that showed the highest item total correlations, plus one extra item to guarantee that each subscale has at least two questions. The Awareness subscale was not included in the DERS-16 because of prior research showing that it was not supported (Bardeen et al., 2012). In a clinical sample of women receiving emotional regulation group therapy for self-harm in Sweden (n = 96, mean age = 25.37(6.63) years, 100% female), as well as in American community samples, Bjureberg et al. (2016) found that the DERS-16 exhibited excellent validity and reliability

and correlated significantly and positively with the original DERS-36. One community sample was targeted at recruiting interested community members who experienced mood or behavioural problems (n = 102, mean age = 24.68 (10.27 years), 63.64% female, while the other community sample comprised young women who were recruited through random sampling techniques (n = 482, mean age = 21.75 (2.23 years), 100% female).

Numerous follow-up studies have attempted to replicate and examine the psychometric qualities of these short-form questionnaires since their creation (Charak et al.,2019; Hallion et al.,2018; Skutch et al.,2019). Investigations have consistently shown that all three of the brief reports are valid, dependable, and have an acceptable factor-fit. Nevertheless, there is still debate regarding the ideal abbreviation despite these studies. To be more precise, every study has conducted somewhat different research and come to slightly different conclusions, which has led to varying suggestions regarding the ideal condensed form of the DERS.

Similarly, the lesser documented version is that of parent form developed by Bunford et al. (2018) for DERS. The need for the same arises when there was an insight eliciting that other than the respondents bias it is also the pathology that might interfere in clouding the various measures of the test. This highlights the cultural difference as well that brings in the need to validate the study across cultures. The self-report alone does not suffice for the same and therefore requires the adult version to substantiate the findings in hand.

Emotional dysregulation is a construct of great relevance for clinical psychology, given that it is a process involved in the emergence and maintenance of most mental disorders, quality of life, and self-esteem (Balaguer Pich et al., 2018; Brown and Barlow, 2009). These factors lead to the current study's goal of adapting, confirming, and minimizing the Difficulties in Emotional Regulation Scale (DERS) for adolescent population in India, adapting and validating the construct as well as adapting the parent form for the same.

Literature Review

DERS 16

The scale devised by Bjureberg et al., (2016), Difficulties in Emotion Regulation Scale is a theoretically driven and psychometrically sound self-report measure for emotional difficulties. It has been established on a clinical sample of 96 and community sample of 102 and 482. Realizing the difficulty of administration of the lengthier questionnaire the need for a briefer version of the

same came up for a broad clinical and research utility. DERS differed from the DERS 36 in the number of questions and the dimensions involved the current dimensions included(1) nonacceptance of negative emotional responses (Nonacceptance), which evaluates the reluctance to embrace certain emotional reactions, especially negative ones, and the inclination to regulate emotions. (2) challenges in executing goal-directed conduct during the experience of unpleasant emotions (Goals), including items that evaluate the capacity to act in alignment with desired objectives amidst negative emotional states. (3) Impulse control difficulties arise during the experience of negative emotions, highlighting that emotional dysregulation entails a failure to diminish the urgency or impulse linked to the negative emotion, thereby impairing the individual's capacity to regulate behavior. (4) restricted access to emotion regulation methods, characterized by inflexibility in using adaptive emotion regulation techniques in response to situational demands during the experience of distressing emotions (Strategies), and (5) Lack of emotional clarity pertains to an insufficient comprehension of the nature of one's emotional reactions or challenges in discerning the causes of one's emotions (Clarity). The omitted feature to enhance the quality of fit was the absence of emotional awareness (Awareness), which defines emotion dysregulation as the inability to feel and distinguish a complete spectrum of emotions.

The study was conducted in 2 phases one to measure the construct and the other to measure the same on the lines of emotion regulation, psychopathology, and clinically relevant behavior on a larger population. The correlations between the subscales of DERS-16 and DERS-36 were established, ranging from 0.04 to 0.85 and from 0.14 to 0.90, respectively. Consequently, research on the reliability and validity of DERS-16 indicates that it is not significantly different from DERS-36 and may be favored for its reduced item count and enhanced applicability.

Looking at the utilitarian benefit many stake holders have undertaken to adapt DERS-16 to their culture such as Arabic (Fekih-Romdhane et al., 2023), Finnish (Westerlund & Santtila, 2018), Brazilian (Miguel et al., 2016) and Turkish. In the Arabic study (Fekih-Romdhane et al., 2023) their findings from the Confirmatory Factor Analysis confirmed the five-factor solution of the DERS-16, thus providing additional support to the cross-cultural validity of the scale. The five-factor structure of the DERS-16 has been consistently supported in the original scale development study (Bjureberg et al., 2016), as well as in Finnish (Westerlund & Santtila, 2018) and Brazilian (Miguel et al., 2016) population-based samples. The

studies using psychopathologies such as that of Borderline personality Disorder, Substance use disorder, Self-harm tendencies and risky sexual behavior showed a high level of convergence with DERS 16 thus increasing clinical utility and strengthening the evidence of its adequacy in clinical populations as a screening and monitoring measure (Sörman et al., 2021).

The challenge of managing emotions intensifies throughout adolescence and may correlate with psychopathology. Therefore, it is essential to create instruments for identifying teenagers at risk of emotional challenges. This research sought to evaluate the reliability and validity of a concise questionnaire in a sample of Turkish adolescents. A total of 256 individuals (mean age $= 15.51 \pm 0.85$ years) were recruited. They finalized the first edition of the Difficulties in Emotion Regulation Scale (DERS-36), a condensed iteration of DERS (DERS-16), the Barrett Impulsivity Scale (BIS-11), and the Toronto Alexithymia Scale (TAS). The psychometric features of DERS-16 were examined by confirmatory factor analysis, Cronbach's alpha, and Pearson correlation analysis. The research indicated that the DERS-16 scale is statistically comparable to its original version regarding scale structure and has good validity and reliability. Furthermore, the disparities between the DERS-16 and DERS-36 were negligible.

But the problem remained that allfacets of society were not represented as the questionnaire was supplied via phone, gender difference could not be delineated. Study by Kanj et al., 2023 on difficulty in emotion regulation implication on Lebanese population as a mediation between childhood trauma and development borderline personality disorder. It was conducted on a population of 411 Lebanese using snowballsampling. In order to measure Difficulty in emotion regulation DERS 16 was used. The findings suggest that there was an indirect relationship between Borderline Personality Disorder and childhood emotional abuse scores on the DERS-16. Significant correlations were found between higher emotional abuse scores and higher DERS-16 scores, which were then significantly correlated with higher BPQ scores. Therefore, drawing in evidence for sensitivity towards pathology that it was developed against (Kanj et al., 2023). With convergent validity it gets proven that the 5 factor model it is representative of most of psychopathologies with emotional dysregulation component excepting for autism as t5he emotional awareness has been taken off (Bejureberg et al.,2015).

DERS Parent Form

Emotional dysregulation is a transdiagnostic feature linked to externalizing disorders (e.g., oppositional defiant disorder), internalizing disorders (e.g., anxiety, depression), and, as defined above, neurodevelopmental disorders.(Bunford, Evans, & Wymbs, 2015; Mazefsky et al., 2013) such as attention deficit/hyperactivity disorder (ADHD; Bunford, Evans, Becker, & Langberg, 2015; Bunford, Evans, et al., 2017; Bunford, Evans, & Langberg, 2014; Graziano & Garcia, 2016; The urgency for the scale developed came in as it was noted that exclusive dependence on self-reporting in teenagers hinders thorough assessment of eating disorders. Although employing comparable assessment methods among multiple respondents is crucial for obtaining contextual information (i.e., contexts in which a characteristic is present or absent; De Los Reyes et al., 2015) and is regarded as best practice in evaluating youth mental health (Youngstrom, Choukas-Bradley, Calhoun, & Jensen-Doss, 2015), the lack of valid measures of emotional disturbance across informants hinders parallel assessment between adolescents and their parents (Mash & Hunsley, 2005). This conceptualization encompasses the modulation of emotional arousal and its physiological, experiential, and behavioral manifestations, alongside the acceptance, awareness, and comprehension of emotions, as well as the capacity to act appropriately despite intense emotions (Gratz & Roemer, 2004). The findings further substantiate the transdiagnostic applicability of the measure, since they demonstrate that the DERS or its subscales may predict disorder status. Reliability and validity were assessed in a large online community sample (Study 1: n = 978; Mage = 13.52 years; SD = 1.93) and in two teenage samples with ADHD (Study 2, Sample 1: n = 78; Mage = 12.12 years; SD = 0.91; Sample 2: n = 206; Mage = 15.35 years; SD = 0.85). A four-factor solution of the DERS-P was established in Study 1 and validated in Study 2, with the factors exhibiting satisfactory internal consistency. The community sample was often assessed as exhibiting lower levels of dysregulation compared to the ADHD group. Evidence was gathered to support convergent, concurrent, and incremental validity. These results provide first evidence that the DERS-P is a psychometrically valid parent-report instrument for assessing emotion dysregulation in teenagers aged 11 to 17 years. Having said that few limitations that encourage further research is consideration of 6 factor structure to 5, second comparing parent rated measure with other parent rated measure and the problems involved with backward coding that helps get future research in this area. Total score ranging from 29-145 rated over a likert scale from 1-5, with1 being almost never to 5 being almost always.

Adolescence and emotion regulation

Adolescence is a critical phase of human development marked by substantial changes in physical, cognitive, and behavioral dimensions. During these phases, teenagers exhibit many roles, including protective, accommodating, rebellious, and generous behaviors towards others (Bailen et al., 2018). This phase is characterized by the frequent occurrence of both good and negative emotions, emotional instability, powerful emotional experiences, and restricted access to emotion management techniques. Due to the fragility of emotional experiences, it is essential for teenagers to manage their emotions proficiently. The capacity to manage emotions fosters healthy development by forecasting life satisfaction, academic success, and teenage resilience. Nonetheless, a failure to control emotions, characterized by maladaptive techniques or diminished awareness of emotional states, forecasts depression, anxiety, suicidal thoughts, sleep disturbances throughout adolescence, and violent conduct (Mohd Ali et al., 2022).

The distinctions between genders during adolescence significantly influence the regulation of emotions. In conventional perspectives regarding gender, females are often perceived as more nurturing and accommodating, whereas males are viewed as more agentic. It is anticipated that girls articulate their emotions to facilitate social connections with others. Conversely, boys are conditioned to suppress emotions like sadness and anxiety in order to project an image of masculinity. . Research on Emotion Regulation strategies reveals notable gender differences in Expressive Suppression (ES), with boys exhibiting a greater tendency to employ this strategy compared to girls. However, no such differences are observed in Cognitive Reappraisal (CR). This makes it a continuing study to understand emotional Dysregulation in a better manner as manifested by the adolescent (Mohd Ali et al., 2022).

Culture and Emotion Regulation

In an anthropological study by Mauss et al., (2008) they pointed out three important outcomes of culture's influence on culture. At its core, it ought to impact the extent to which individuals feel compelled to manage their emotional states. Emotions, in a theoretical context, represent potent internal experiences that can affirm an individual's uniqueness while also possessing the capacity to disturb social cohesion. People from interdependent cultures ought to be more inclined than those from independent cultures to learn how to control their emotions. This essential concept is further substantiated by the observation that Asian Americans indicated a higher frequency of employing emotion regulation compared to their European American counterparts (Mauss et al., 2008). In one such standardized laboratory anger provocation experiment, Asian Americans experienced and facially expressed less anger than European American, implying that these

inclinations might correspond to real emotion control (Mauss et al., 2008) Thiscultural group effect was mediated by Asian-Americans' stronger preferences for emotion regulation. Accordingly, preliminary data indicates that cultural factors influence people's motivation to initiate emotion regulation and possibly even the likelihood that it will occur. Therefore, culture shapes interpretation of emotionally dysregulated manner or not. The influence of culture plays a significant role in determining the extent to which individuals feel compelled to manage their emotional responses. The influence of culture determines the adaptive or maladaptive nature of emotion regulation. A sophisticated examination of cultural factors will enhance our comprehension of emotion regulation.

Indian studies on Emotion Dysregulation

The Hindi Version of the Difficulties in Emotion Regulation Scale, DERS H (Bhatnagar et al., 2020) seeks to investigate the factor structure of the DERS-H among 434 healthy participants (303 females, 131 males) from a middle socio-economic background. The creation of the tool, informed by the results of both exploratory and confirmatory factor analyses (CFA), failed to validate any of the proposed one-, six-, or five-factor models. The CFA, while providing a satisfactory fit for the first-order six-factor model, did not demonstrate a good fit for the second-order model. Nonetheless, upon the elimination of the Awareness dimension, both the first-order and the second-order modified five-factor models demonstrated suitable fits to the data. The revised DERS-H, along with its five sub-domains, demonstrated commendable reliability and validity, in addition to exhibiting factor structure invariance across different genders and age groups.The 5 domains retained are: (1) nonacceptance of negative emotional responses (Nonacceptance), (2) difficulties engaging in goal-directed behavior when experiencing negative emotions (Goals), which includes items assessing the ability to behave in accordance with desired goals, when experiencing negative emotions, (3) impulse control difficulties when experiencing negative emotions (Impulse), which emphasizes that emotion dysregulation involves the inability to reduce the urgency or impulse associated with the negative emotion (by altering the intensity of an emotion), so that the individual is not able to control her or his behavior, (4) limited access to emotion regulation strategies (Strategies), which involves the inflexibility in the use of healthy emotion regulation strategies according to the demands of the situation when experiencing uncomfortable emotions, and (5) lack of emotional clarity (Clarity), which refers to not having a clear understanding of the nature of one's emotional responses or difficulty in understanding the origins of one's emotions. The findings indicate that the modified version serves as a psychometrically robust instrument, exhibiting a stable factor structure for assessing the second-order construct of emotion regulation difficulties. However, it is recommended that further

research be conducted to validate this psychometric property in relation to the five-factor model and to explore its application in various regions of the country.

Need For the Study

The major obstacle when conducting Emotion Dysregulation research in India with adolescent samples is that there are fewer studies that have developed or validated an instrument to measure Emotional Dysregulation strategies amongst Indian adolescents in the Hindi language. Studies of Emotional Dysregulation in the Indian population are mainly centered on adults and a Hindi version of the DERS which majorly targets adult samples has been developed. While Emotional Dysregulation studies amongst Indian adolescents remain scarce, and it is difficult to draw a reasonable conclusion regarding the development of Indian adolescents' Difficulty in Emotion Regulation Scale 16. Therefore, this study also hopes to contribute to future studies on understanding emotional dysregulation among adolescents in India.

Comprehending emotional dysregulation is essential for individuals in collectivist cultures, as research indicates that there are distinct variations in emotional regulation strategies when comparing individualistic and collectivistic societies. Consequently, it is essential to create an Indian adaptation of the DERS 16, which was initially developed in English, to enhance research within Indian cultures and to gain insights into the dynamics of emotion regulation in collectivistic societies.

There has been fewer studies that have concentrated on the adolescent, deriving from the critical period where the emotional regulation consolidation majorly takes place. It makes it imperative to investigate about the same. Therefore, the study concentrates toto adapt DERS-16 on Indian adolescent aged from 12-18 years old as well as looking into the effect of gender difference on emotion regulation.

Most of the studies have always used a self-report measure but an inter-rater method shall provide for greater validity of results obtained in adolescents. It has shown that in certain pathology such as that of ADHD believing the self-report becomes difficult as in with most of the other checklist a parent form shall necessitate confirmatory result. The biases can be reduced. Therefore, an adaptation for Difficulties in Emotion Regulation scale - Parent Report by Bunford et al., (2018) has been undertaken.

In light of the various considerations previously discussed, the aim of the present study was to examine the psychometric characteristics of the Indian adaptation of the DERS 16 within a sample of adolescents aged 12 to 18 years. The researchers conducted an examination of gender invariance in the realm of emotion regulation among adolescents.

Methodology

Aim of the study: The aim of the present study is to modify and standardize the Difficulties in Emotion Regulation Scale (DERS-16) on 12–18-year-old adolescents and screen them for an early intervention as well as adapting DERS-P Difficulties in Emotion Regulation Scale Parent Form on respective parents of the adolescent participants.

Objectives

1. To adapt the existing Difficulties in Emotion Regulation Scale (DERS -16) 16 to Indian context as well as adapting Difficulties in Emotion Regulation parent form (DERS-P) versionto the mainland.
2. To check the reliability and validity of the modified Difficulties in Emotion Regulation Scale16 (DERS 16) and Difficulties in Emotion Regulation parent form (DERS-P) of the same for Indian Adolescents and their respective parent/s.

Hypotheses

1. There will be no significant difference in the reliability and validity between the items of modified Indian adaptation of Difficulties in Emotion Regulation Scale 16 (DERS 16 M) and Difficulties In Emotion Regulation Scale 16 (DERS 16).
2. There will be no significant difference in the reliability and validity between the Indian adaptation of Difficulties In Emotion Regulation Scale Parent Form 16 (DERS-P M) Difficulties In Emotion Regulation Scale Parent form/version (DERS-P).

Motivation

Emotional Dysregulation is a transdiagnostic measure. But the necessary influence of culture on the expression and regulation could not be avoided. Therefore, the tool that is adapted or formulated in the mainland can entail efficiently a measurement for clinical purpose be it initial assessment or

the outcome variable. But any scale only reliance on self-report measure, especially in case of children and adolescents does not quite yield satisfactory result. Therefore, adapting the parent form of similar prospect can yield better result of multi rater validity.

Design

This study follows an exploratory analysis.

Sample

The study shall be conducted in the Eastern India, in the state of Jharkhand. The study would include adolescent population ranging from 12-18 years old and their respective parent set. Total sample size would be 300: 150 adolescent and 150 respective parent set. It shall include students from Grade VIII to grade X and their respective parent, from three schools of Ranchi that will be selected for the study. The selection of the schools will be based on random selection to avoid bias. On three schools, pilot study will be conducted after the finalization of the modified assessment. The participants will be selected using stratified random sampling technique. From each grade 50 children and their respective parent set that volunteer will be included in the study keeping in mind that each grade has 3-4 sections comprising of about 40 students each. For the overall sample size, the number of items in the modified checklist will be multiplied by 5 and the result obtained will be our total sample size, so if the total number of items kept in the modified checklist will be 29 then our sample size will be 29 multiplied by 5 giving us 145 as our overall sample.

Inclusion Criteria: Adolescents

- Adolescent of either of the genders- boys and girls
- Those with average level of intelligence
- Adolescent who gives assent.

Parents

- Parents who give their consent.
- Parents who have been staying with the child (for at least 6 months).

Exclusion Criteria: Adolescents

- Adolescent with below average intelligence.
- Adolescent with history of any major physical, neurological, and psychiatric disorder
- Adolescent who do not give assent to participate in the study

Parents

- Parents who do not stay with their child
- Parents suffering from any major physical, neurological, and psychiatric disorders.

Tools

1. **Informed Consent/Assent form:** Consent will be taken from the adolescent's parents and the adolescent. They would be briefed about the research, purpose, and procedure as well as confidentiality of the study and results.
2. **Sociodemographic datasheet:** A background information sheet consisting of information of age, sex, education, religion, domicile, Socio Economic Status, family income etc. will be included.
3. **Standard Progressive Matrices (SPM) (Raven et. al, 1940)** The tests were originally developed by John C. Raven in 1936 In each test item, the subject is asked to identify the missing element that completes a pattern. Many patterns are presented in the form of a 6×6, 4×4, 3×3, or 2×2 matrix, giving the test its name. These were the original form of the matrices, first published in 1938. The booklet comprises five sets (A to E) of 12 items each (e.g., A1 through A12), with items within a set becoming increasingly complex, requiring ever greater cognitive capacity to encode and analyze information. All items are presented in black ink on a white background. The test can be administered individually as well as in group. In each test item, one is asked to find the missing pattern in a series. Each set of items gets progressively harder, requiring greater cognitive capacity to encode and analyze. The test is untimed but generally takes 15-45 minutes and results in a raw score which is then converted to a percentile ranking. The test can be given to hearing and speech-impaired children, as well as non-English speakers. The SPM has a test-retest reliability of 0.86 and internal consistency coefficients ranging from 0.71-0.90. The SPM will be administered in group. After giving instructions, the items shall be presented on a big screen and responses shall be recorded on the response sheets distributed to the children. Every correct answer is scored one point and the overall score is converted to percentile using the

norm table for that age range. For interpretation the percentiles are converted to grades ranging from Grade I (intellectual superior; score lies above 95 percentile) to Grade V (Intellectually impaired; score lies at or below the 5^{th} percentile). The aim of using SPM is that it will help us assess and exclude the children having dull normal or borderline level of intellectual functioning and select the children with average intelligence for our study.

4. **General Health Questionnaire 28 (GHQ)** The GHQ-28 was developed by Goldberg and Hillier in 1979 and is based on an exploratory factor analysis (EFA) of the original GHQ-60. It consist of 28 items interspread amongst 4 dimension: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. The GHQ-28 requests participants to indicate how their health in general has been over the past few weeks, using behavioral items with a 4-point scale indicating the following frequencies of experience: "not at all", "no more than usual", "rather more than usual" and "much more than usual". The minimum score for the 28 version is 0, and the maximum is 84. Higher GHQ-28 scores indicate higher levels of distress. Goldberg suggests that participants with total scores of 23 or below should be classified as non-psychiatric, while participants with scores >24 may be classified as psychiatric, but this score is not an absolute cut-off (Hjelle et al., 2019). The test-retest reliability is 0.73 Cronbach alpha was 0.90-0.95 (Goldberg & Hillier, 1979). For GHQ 28 the value of sensitivity is 59% and specificity75%, respectively (Makowska et al., 2002).
5. **DERS-16 (Difficulties in Emotion Regulation Scale-16 item Version)** The questionnaire was developed after shortening the original DERS form. It consists of 16 items rated on a 5-point positively valanced Likert Scale, with subscales measuring nonacceptance of negative emotions (Nonacceptance, three items), inability to engage in goal-directed behaviors when distressed (Goal, three items), difficulties controlling impulsive behaviors (Impulsivity, 3 items), limited access to emotion regulation strategies perceived as effective (Strategy, five items), and lack of emotional clarity (Clarity, two items). This DERS-16 demonstrated good internal consistency (Cronbach's alpha = .92; Bjureberg et al., 2016) and was strongly associated with the original 36-item version (r = .93) in the original validation sample (Gratz & Roemer, 2004. Subscale scores are calculated as the total score of their respective scale items and the total DERS-16 score is the total of all the subscale scores. Before the translation process, we obtained permission to translate the English

version of DERS-16 from the corresponding author in Bjureberg et al.'s original study. The translation process of DERS-16 will be carried out in six stages primarily (Bjureberg et al., 2015).

6. **DERS-P (Difficulties in Emotion Regulation Scale- Parent Version)** Questionnaire developed by Bunford et al. (2018) comprising of 29 questions to be rated on a five-point Likert scale. The observation is that of a parent here on the child's behavior. In a comprehensive assessment, evidence of reliability and validity was scrutinized within a substantial online community sample (Study 1: n = 978; Mage = 13.52 years; SD = 1.93) as well as in two distinct samples of adolescents diagnosed with ADHD (Study 2, Sample 1: n = 78; Mage = 12.12 years, SD = 0.91; Sample 2: n = 206; Mage = 15.35 years; SD = 0.85). A four-factor solution of the DERS-P was identified in Study 1 and subsequently validated in Study 2, with the factors exhibiting satisfactory internal consistency. The community sample was typically assessed as exhibiting lower levels of dysregulation compared to the ADHD samples. Evidence was gathered to support convergent, concurrent, and incremental validity. The results offer initial support for the DERS-P as a reliable parent-report instrument assessing emotion dysregulation in adolescents aged 11 to 17 years. Total score is from 29-145. The 4 factors are that of catastrophize, negative secondary, attuned and distracted. It also comprises of the reversed items and are marked on the continuity. Before the translation process, we obtained permission to translate the English version of DERS-P from the corresponding author in Bunford et al.'s (2018) original study. The translation process of DERS-P will be carried out in six stages primarily (Bunford et al., 2018).
7. **DERS -H (Difficulties in Emotion Regulation Scale-Hindi Version)** Developed by Bhatnagar et al., (2018) a 25-item questionnaire revised from six factor model of original DERS to five factor model following exploratory factor analysis and Confirmatory Factor Analysis. The score range from 25- 125 and there are 5 dimensions of Non-accept, Goals, Impulse, Strategies and Clarity. It is rated on a 5 pointer Likert scale. Interpreted as a continuous variable. Reliability coefficient being that of .90 for full scale and validity of total is 1 and there is significant to moderate correlation found amidst the scales (Bhatnagar et al., 2018).

Procedure

The scales identified for the study are as follows:

- Difficulties in Emotion Regulation Scale-16 item Version- DERS-16 (Bjureberg et al., 2015).
- Difficulties in Emotion Regulation Scale- Parent Version- DERS-P (Bunford et al., 2018)
- Difficulties in Emotion Regulation Scale-Hindi Version -DERS-H (Bhatnagar et al., 2018)

For Difficulties in Emotion Regulation Scale-16 item Version- DERS-16 the first author Dr Johan Bjureberg of Department of Clinical Neuroscience, Karolinska Institute, Nobels of Sweden was contacted via email requesting permission to adapt his scale DERS-16 to Indian context. He promptly conveyed his agreement to the proposal and requested to send a translated copy upon completion.

For Difficulties in Emotion Regulation Scale- Parent Version- DERS-P the authors contacted via email, LinkedIn and ResearchGate were Nora Bunford, Anna E Dawson, Steven W Evans, George J. DuPaul requesting access to the scale. Finally with Dr George J Du Paul's help a secure email was sent to the first author i.e Dr Nora Bunford from Institute of Cognitive Neuroscience and Psychology, Budapest, Hungary who did promptly reply on the new email address providing permission for adaptation and the required questionnaire to be utilized in the study.

For Difficulties in Emotion Regulation Scale-Hindi Version -DERS-H Dr Rakesh Pandey from Department of Psychology, Banaras Hindu University, Varanasi, India was contacted after multiple emails the scale was secured signing a formal agreement for the same. Along with the access to the instrument, permission to use it in the study was also agreed upon.

Steps of scale translation and adaptation	**Description**
Step 1: Identification of the assessment tool	Detailed research review was done to look for the existing gaps. Research review was mostly related to the use of Difficulties in emotion regulation scale to screen them and offer timely management.
Step 2: Content validity (evaluation by the experts)	The next step will be to evaluate the Difficulties in Emotion Regulation Scale 16 (DERS 16) as well as the parent form (DERS-P)with the help of ten professionals who have had at least 2 years of experience in the field of child and adolescent psychiatry. Based on, their suggestions regarding the addition

	of more items in the existing questionnaire will be obtained and a format will be constructed.
Step 3: Translation of the original instrument	**FORWARD TRANSLATION** The instrument in the source language will be translated into the target language by a minimum of two independent translators, ideally certified, whose native language is the target language of the instrument. The translators will possess fluency in both the source language and the target language of the instrument, and it is preferable that they also have substantial experience with the cultures associated with both languages. Furthermore, the two translators will possess unique backgrounds. The initial translator will possess a profound understanding of health care terminology as well as the subject matter related to the construct of the instrument in the target language. The second translator will possess a deep understanding of colloquial phrases, health care terminology, idiomatic expressions, and emotionally charged language prevalent in the target language. The second translator may lack familiarity with medical terminology and the framework of the instrument. This methodology will produce two translated iterations that encompass terminology and phrases reflecting both the medical lexicon and the vernacular, along with its cultural subtleties. **BLIND BACKWARD TRANSLATION** The initially translated instrument will be translated back into the original language by two other independent translators with the same qualifications and characteristics described above. For this step, the translators' mother language will be the language of the original instrument, and they would be completely blind to the original version of the instrument (they have never seen the original version of the instrument). The characteristics of a back translator would be the same as those mentioned above.
Step 4: Pilot study (evaluation by target population)	The next step will be to conduct a pilot study on the12-18-year adults. The DERS-16 and DERS-P modified form will be applied on the adolescents andparents respectively.

Step 5: Cognitive Debriefing	This step will be used to further support the conceptual, semantic and content equivalency of the translated instrument and further improve the structure of sentences used in the instructions and items of the pre-final assessment device to be easily understood by the target population prior to psychometric testing. Recommendations are made with respect to 4 areas: • Semantic Equivalence for multiple meanings to a given item. • Idiomatic Equivalence for colloquialisms or idioms. • Experiential Equivalence for a given task that may not be experienced in the target language even if it is translatable. • Conceptual Equivalence for words with different conceptual This shall be achieved with an Expert Panel comprising of 10 members holding expertise. Expert Panel will comprise of individuals not involved in any of about the content areas of the construct of the instrument and the target population in which the instrument will be used and whose mother language is the translated language of the instrument. Each member of the committee who will rate the instructions, response format or any item of the instrument as unclear is asked to provide suggestions as to how to rewrite the statements and make the language clearer.
Step 6: Full psychometric testing of the pre-final version	This last step will be used to establish the initial full psychometric properties of the newly translated, adapted instrument with a sample of the target population of interest. For the purpose of validity assessment, 80 adolescents and 145 parents of respective adults will be randomly assessed by the researcher.

Source: Valmi D. Sousa and R. Wilaiporn. Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: a clear and user-friendly guideline. Journal of Evaluation in Clinical Practice (2011).

Interim Statistical Plan

The statistical approaches which will be used in the study will be scale and item analysis, Pearson's correlation analysis, exploratory factor analysis and confirmatory factor analysis. Statistical analysis of the obtained data will be done using the Statistical Package for the Social Sciences (SPSS) (SPSS version 25.0) International Business Machines (IBM), Chicago, Illinois, U.S.A.

Significance of the Study

The present study will contribute to the existing literature by exploring the factors influencing emotional regulation contributing to dysregulation Indian Adolescents. This shall help in formulating culturally adapted version encapsulating cultural sensitivity and increasing the applicability for understanding the Indian Adolescents in better manner (Bhatnagar et al.,2018). An effective briefer tool (Bjureberg et al.,2016) to help clinician diagnosis and management better. Involving the system of multi rater analysis (Bunford et al., 2018) by including parents in the assessment thus increasing the objectivity rather than informal interview a constructive measure for understanding from the overt presentation of the Adolescents.

Relevance to the present-day problem and need of the society

In the current time with the growing body of research it becomes imperative to develop tools sensitive to one's cultural context and the population in question. With the advent of globalization, the stakes have risen in management of emotional regulation as the exposure of information, digital medium preponderance and unprecedent fast life gives little that can be controlled. This in turn has given rise to problems of addiction, smartphone use, self-harm behaviors and risky sexual practices (Sabatier et al., 2017) amongst the adolescent. The scale shall help in better understanding of emotion regulation difficulties and pave areas of importance in therapy such as that of expression vs regulation majorly. The multi rater format shall enhance the reliability and give an effective measure assisting in clinical formulation as well as noting therapy progress. This shall also highlight the difference of construct in western vs Indian view of management and expression of emotion thus contributing to the literature. It shall also pave the path doe understanding the gender difference in management, comprehension, and expression of emotion.

Future Direction

To standardize in other dialects of the mainland and to try out on bigger population as well as clinical samples.

Tentative chapters of the thesis

- **Introduction and need for the study**
- **Review of literature**
- **Aims and objectives**
- **Hypotheses**
- **Research design and methodology**
    - **Study design and venue**
    - **Sample**
    - **Instruments/ tools**
    - **Procedure**
    - **Statistical analysis**
- **Results**
- **Discussion**
- **Summary and conclusion**
- **Limitations and future directions**
- **Bibliography**
- **Appendices**

*This synopsis is tentative, which may be modified depending upon the availability of cases, tools and other situatio

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APPENDIX 1

APPENDIX 1

भारत सरकार
केन्द्रीय मनाचिकित्सा संस्थान
राँची – 834006

<u>सूचित सहमति</u> पत्र

परियोजना का शीर्षक:

" भारतीय किशोरों पर भावना विनियमन स्केल 16 (डीईआरएस-16) और पैरेंट फॉर्म (डीईआरएस-पी) में कठिनाई का हिंदी अनुकूलन और सत्यापन"

जांचकर्ता

1. सुश्री संतोना पांडा (एम.फिल.)
2. डॉ. निशांत गोयल, MD, DPM
3. डॉ. अमूल रंजन सिंह, एम.फिल., पीएच.डी.

प्रतिभागी

नाम: उम्र/जन्म तिथि:
पता:

संभावित निधि एजेंसी:

प्रतिभागी सहमति

भाग १: सूचना पत्र प्रतिभागी के लिए

1. **अध्ययन का उद्देश्य**:आपसे उपर्युक्त अनुसंधान अध्ययन में भाग लेने का अनुरोध किया जा रहा है। नामांकन से पहले, पढ़ सकते हैं और निम्न जानकारी को समझते हैं, हर समय आपको ऐसा करने की जरूरत है!
   DERS-16 और DERS P का हिंदी संस्करण विकसित करने के लिए, पायलट और DERS16 और DERS P के अनुवादित हिंदी संस्करण को मान्य करें।

2. **अध्ययन प्रक्रियाएं**: इस अध्ययन में, अध्ययन के समावेश और बहिष्करण मानदंडों के अनुसार आस-पास के स्कूलों के किशोरों और उनके संबंधित माता-पिता को शामिल करके डेटा एकत्र किया जाएगा और बच्चों और माता-पिता दोनों को संबंधित प्रश्नावली दी जाएगी। हम डेटा संग्रह प्रक्रिया के दौरान किशोरों और उनके माता-पिता का मार्गदर्शन और निरीक्षण करने के लिए हमेशा वहां रहेंगे। डेटा एकत्र होने के बाद, इसका आगे विश्लेषण किया जाएगा।
3. **अध्ययन का जोखिम**: शून्य
4. **अध्ययन के लाभ**: इस अध्ययन से हम रोगियों में मनोवैज्ञानिक और मानसिक लक्षण का अध्ययन करेंगे, जो तर्कसंगत फार्माकोथेरेपी और बेहतर प्रबंधन में और मदद करेंगे।

5. **जटिलतायें**: शून्य
6. **नुकसान भरपाई:** शून्य
7. **गोपनीयता**: आपकी अध्ययन की भागीदारी का रिकॉर्ड गोपनीय रखा जाएगा। डेटा का कोई भी प्रकाशन आपके नाम से नहीं किया जाएगा। सहमति फॉर्म पर हस्ताक्षर करके, आप नियामक प्राधिकरणों और संस्थागत नैतिक समिति को अपने अध्ययन से संबंधित चिकित्सा रिकॉर्ड साझा करने का अधिकार देते हैं।
8. **प्रतिभागियों के अधिकार**: आपको सी०आई०पी० में भविष्य के उपचार से गुजरने के लिए आपके या आपके परिवार के अधिकारों के किसी भी पूर्वाग्रह के बिना अध्ययन के दौरान किसी भी समय अध्ययन से बाहर निकलने का अधिकार है।
9. **अध्ययन में भागीदारी के विकल्प**: आप अस्पताल से सामान्य रूप से इलाज जारी रख सकते हैं।

अध्ययन के दौरान या उसके बाद किसी भी समय, आप अध्ययन के बारे में और जानकारी प्राप्त कर सकते हैं ।

भाग २: प्रतिभागी सहमति

मुझे अध्ययन को समझाया गया है और इस फॉर्म की सामग्री पढ़ी है । मुझे प्रश्न पूछने और उन्हें रखने का मौका दिया गया है और मैं इससे संतुष्ट हूँ।

मैं अध्ययन में दाखिला लेने के लिए तैयार हूँ

अभिभावक का नाम:

अभिभावक का हस्ताक्षर/बाएँ अंगूठे का निशान:

दिनांक:

रोगी के साथ संबंध:

जांचकर्ता का बयान:
मैं, जाँचकर्ता, ,ने अभिभावक को उसी भाषा में समझाया है, जिसे वह समझते है। मैंने अध्ययन की प्रक्रिया, लाभ और हानि को समझा दिया है ।

जांचकर्ता का हस्ताक्षर:	साक्षी का हस्ताक्षर:
जांचकर्ता का नाम:	साक्षी का नाम:
तिथि:	तिथि:

APPENDIX

GOVERNMENT OFINDIA
CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

HINDI ADAPTATION AND VALIDATION OF DIFFICULTIES IN EMOTION REGULATION SCALE 16 (DERS-16) AND PARENT FORM (DERS-P) ON INDIAN ADOLESCENTS

INFORMED CONSENT FORM

Investigators' Details:

1. Ms. Santona Panda (M.Phil.)
2. Dr. Nishant Goyal, MD (Psychiatry)
3. Dr. Amool Ranjan Singh M.Phil., Ph.D.

Participant Details:

1. **Name of Adolescent:**
2. **Age/Date of Birth:**
3. **Name of the Guardian/Caregiver:**
4. **Address:**

Parent/Guardian/Caregiver Consent Form

Part I: Information Sheet for Patient and/or Guardians/Caregivers

1. **Purpose of Study**: You are requested to participate in the above-mentioned study. You can read and understand this information before giving your permission for the study and can read this information at any point. Ensure that you understand the information provided to you. The present study aims at adapting and validating Difficulty in Emotion Regulation Scale (DERS-16)and Parent form (DERS-P)on Indian Adolescent.

2. **Process of Study:** In this study, data would be collected by including adolescent and their respective parents from nearby schools according to inclusion and exclusion criteria of the study and both the children and the parents would be given the respective questionnaires to be rated. We will be always there to guide and observe the adolescents and their parents during the data collection process. After the data has been collected it will be further analyzed.

3. **Risk from the Study:** None

4. **Benefits from the Study:** In this study, we would be able to assess school going adolescents for emotional dysregulation as early as 12-18 years so that those who have been screened can be given early intervention for better outcomes.

5. **Complications:** None

6. **Compensation:** None

7. **Confidentiality**: Your participation in this study would be kept confidential. No data/part of data would be published with your name in it. By signing this consent from, you authorize investigative agency and Institute Ethics Committee to share the records related to you.

8. **Rights of the Participants**: You and your family have the right to withdraw your consent from the study during any part of the study without any reason.

9. **Options for Participation in the Study**: You have the options for agreeing to participate or not participate in the study.

You can ask for more/further information during and/or after the completion of the study

Part 2: **Parent/Guardian/Caregiver Consent**

I have read and have been explained the information contained in this form. I was given the chance to ask and put forth questions related to the study. I have been satisfied completely.

I hereby give my consent for my child's participation in the Study.

Name of the Adolescent:

Signature/Left Thumb Impression of Parent/Caregiver:

Date:

Relationship with the Child:

Testimony of the Investigator:

I, Santona Panda, the investigator, have explained to the adolescent's caregiver in the language in which they are conversant. I have explained the procedure, benefits, and harm of the study to them.

Signature of the Investigator:	Signature of the Witness:
Name of the Investigator:	Name of the Witness
Date:	Date:
Place:	Place:

APPENDIX 2

GOVERNMENT OF INDIA
CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

"HINDI ADAPTATION AND VALIDATION OF DIFFICULTIES IN EMOTION REGULATION SCALE 16 (DERS-16) AND PARENT FORM (DERS-P) ON INDIAN ADOLESCENTS"

SOCIODEMOGRAPHIC DATA SHEET	
Serial no:	Date:
Name:	Father's Name:
Address:	
Age	
Sex	1. Male 2. Female

Religion	1. Hindu 2. Muslim 3. Christian 4. Others
Educational level	1. Illiterate 2. Primary 3. Middle 4. Secondary 5. Higher
Occupation	1. Employed 2. Unemployed 3. Student
Socio-Economic status	1. LSES 2.MSES 3.HSES
Marital status	1. Married 2. Unmarried 3. Divorced 4. Widowed
Family type	1. Nuclear 2. Joint
Habitat	1. Rural 2. Urban

APPENDIX 3

GOVERNMENT OF INDIA
CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

The scaled GHQ

GENERAL HEALTH QUESTIONNAIRE

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.
It is important that you try to answer ALL the questions.
Thank you very much for your cooperation.

HAVE YOU RECENTLY:

A1.	Been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2.	Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3.	Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4.	Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual

A5.	Been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6.	Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7.	Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1.	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2.	Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3.	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4.	Been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5.	Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6.	Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7.	Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
C1.	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2.	Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3.	Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4.	Been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5.	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6.	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7.	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
D1.	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2.	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3.	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4.	Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5.	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6.	Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7.	Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A ☐ B ☐ C ☐ D ☐ TOTAL ☐

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STANDARD PROGRESSIVE MATRICES
SETS A, B. C, D, & E

NAME----------GROUP NO.----------

PLACE---------- DATE----------

AGE----------BIRTHDAY----------

TEST BEGUN----------TEST ENDED----------

A	A	B	B	C	C	D	D	E	E
A-01		B-01		C-01		D-01		E-01	
A-02		B-02		C-02		D-02		E-02	
A-03		B-03		C-03		D-03		E-03	
A-04		B-04		C-04		D-04		E-04	
A-05		B-05		C-05		D-05		E-05	
A-06		B-06		C-06		D-06		E-06	
A-07		B-07		C-07		D-07		E-07	
A-08		B-08		C-08		D-08		E-08	
A-09		B-09		C-09		D-09		E-09	
A-10		B-10		C-10		D-10		E-10	
A-11		B-11		C-11		D-11		D-11	
A-12		B-12		C-12		D-12		E-12	
TOTAL									

AGE----------TOTAL----------

GRADE----------PERCENTILE----------

SIGNATURE OF TESTER----------

Raven, J. C. (1938). Raven standard progressive matrices. *Journal of Cognition and Development*.

Difficulties in Emotion Regulation Scale - 16 item version (DERS-16)

Instructions:

Please indicate how often the following statements apply to you by selecting the appropriate option for each item.

		Almost Never	Sometimes	About half the time	Most of the time	Almost always
1	I have difficulty making sense out of my feelings	1	2	3	4	5
2	I am confused about how I feel	1	2	3	4	5
3	When I am upset, I have difficulty getting work done	1	2	3	4	5
4	When I am upset, I become out of control	1	2	3	4	5
5	When I am upset, I believe that I will remain that way for a long time	1	2	3	4	5
6	When I am upset, I believe that I'll end up feeling very depressed	1	2	3	4	5
7	When I am upset, I have difficulty focusing on other things	1	2	3	4	5
8	When I am upset, I feel out of control	1	2	3	4	5
9	When I am upset, I feel ashamed with myself for feeling that way	1	2	3	4	5
10	When I am upset, I feel like I am weak	1	2	3	4	5
11	When I am upset, I have difficulty controlling my behaviours	1	2	3	4	5
12	When I am upset, I believe that there is nothing I can do to make myself feel better	1	2	3	4	5
13	When I am upset, I become irritated with myself for feeling that way	1	2	3	4	5
14	When I am upset, I start to feel very bad about myself	1	2	3	4	5
15	When I am upset, I have difficulty thinking about anything else	1	2	3	4	5
16	When I am upset, my emotions feel overwhelming	1	2	3	4	5

Bjureberg, J., Ljótsson, B., Tull, M. T., Hedman, E., Sahlin, H., Lundh, L.-G., Bjärehed, J., DiLillo, D., Messman-Moore, T., Gumpert, C. H., & Gratz, K.L. (2016). Development and Validation of a Brief Version of the Difficulties in Emotion Regulation Scale: The DERS-16. Journal of Psychopathology and Behavioral Assessment, 1–13. http://doi.org/10.1007/s10862-015-9514-x

Difficulties in Emotion Regulation Scale – Parent version (DERS-P)

Please indicate how often the following statements apply to your child by writing the appropriate number from the scale below on the line beside each item:

1. Almost never (0-10%)
2. Sometimes (11-35%)
3. About half the time (36-65%)
4. Most of the time (66-90%)
5. Almost always (91-100%)

DERS-P					
1. My child is clear about his/her feelings.	1	2	3	4	5
2. My child pays attention to how he/she feels.	1	2	3	4	5
3. My child experiences his/her emotions as overwhelming and out of control.	1	2	3	4	5
4. My child is attentive to his/her feelings.	1	2	3	4	5
5. My child knows exactly how he/she is feeling.	1	2	3	4	5
6. My child cares about what he/she is feeling.	1	2	3	4	5
7. When my child is upset, he/she acknowledges his/her emotions.	1	2	3	4	5
8. When my child is upset, he/she becomes angry with him/herself for feeling that way.	1	2	3	4	5
9. When my child is upset, he/she becomes embarrassed for feeling that way.	1	2	3	4	5
10. When my child is upset, he/she has difficulty getting work done.	1	2	3	4	5
11. When my child is upset, he/she becomes out of control.	1	2	3	4	5
12. When my child is upset, he/she believes that he/she will remain that way for a long time.	1	2	3	4	5
13. When my child is upset, he/she believes that he/she will end up feeling very depressed.	1	2	3	4	5
14. When my child is upset, he/she has difficulty focusing on other things.	1	2	3	4	5
15. When my child is upset, he/she feels out of control.	1	2	3	4	5
16. When my child is upset, he/she feels ashamed with him/herself for feeling that way.	1	2	3	4	5
17. When my child is upset, he/she knows that he/she can find a way to eventually feel better.	1	2	3	4	5
18. When my child is upset, he/she feels like he/she is weak.	1	2	3	4	5
19. When my child is upset, he/she feels like he/she can remain in control of his/her behavior.	1	2	3	4	5
20. When my child is upset, he/she feels guilty for feeling that way.	1	2	3	4	5
21. When my child is upset, he/she has difficulty concentrating.	1	2	3	4	5
22. When my child is upset, he/she has difficulty controlling his/her behaviors.	1	2	3	4	5
23. When my child is upset, he/she believes that there is nothing he/she can do to make him/ herself feel better.	1	2	3	4	5
24. When my child is upset, he/she becomes irritated with him/herself for feeling that way.	1	2	3	4	5
25. When my child is upset, he/she starts to feel very bad about him/herself.	1	2	3	4	5
26. When my child is upset, he/she loses control over his/her behaviors.	1	2	3	4	5
27. When my child is upset, he/she has difficulty thinking about anything else.	1	2	3	4	5
28. When my child is upset, it takes him/her a long time to feel better.	1	2	3	4	5
29. When my child is upset, his/her emotions feel overwhelming.	1	2	3	4	5

डी० इ० आर० एस०

नीचे दिए गए मापनी से उपयुक्त अंक का चयन करते हुए यह इंगित कीजिए कि निम्नांकित कथन किस आवृत्ति में या कितनी बार आप पर लागू होते हैं। मापनी से उपयुक्त अंक का चयन करते हुए अपने उत्तर को प्रत्येक कथन के बगल में बने कोष्टक में अंकित कीजिए।

1	2	3	4	5
लगभग कभी नहीं (0-10%)	कभी.—कभी (11-35%)	लगभग आधा समय (36-65%)	प्रायः या अक्सर (66-90%)	लगभग हमेशा (91-100%)

( ) 1. मै अपने अनुभूतियों (मनोभावों) के बारे में स्पष्ट हूँ।

( ) 2. मैं इस बातपर ध्यान रखता/रखती हूँ कि मैं कैसा अनुभव करता/करती हूँ।

( ) 3. मैं अनुभव करता/करती हूँ जैसे मेरे मनोभाव अत्यधिक तीव्र एवं नियंत्रण के बाहर हैं।

( ) 4. मैं कैसी अनुभूति कर रहा/रही हूँ इसकी समझ मुझमें नहीं है।

( ) 5. मुझे अपने अनुभूतियों (मनोभावों) को समझने में कठिनाई होती है।

( ) 6. मैं अपने भवनाओं या अनुभूतियों के प्रति सचेत रहता/रहती हूँ।

( ) 7. मै यह स्पष्ट रूप से जानता/जानती हूँ कि मैं कैसी अनुभूति कर रहा/रही हूँ।

( ) 8. मैं इस बात की परवाह करता/करती हूँ कि मैं कैसी अनुभूति कर रहा/रही हूँ।

( ) 9. मैं कैसा महसूस करता/करती हूँ इसके बारे में मैं उलझन या दुविधा में रहता/रहती हूँ।

( ) 10. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं अपने भावनाओं या अनुभूतियों पर ध्यान देता/देती हूँ।

( ) 11. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं वैसा अनुभव करने के लिए स्वयं पर ही क्रोधित होता/होती हूँ।

( ) 12. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं वैसा अनुभव करने के लिए मैं झेंप (संकोच या लज्जित महसूस करना) जाता/जाती हूँ।

( ) 13. जब मैं भावनात्मक रूप से परेशान या (व्याकुल) व्यथित रहता/रहती हूँ तो मुझे अपना काम पूरा करने में कठिनाई होती है।

( ) 14. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं नियंत्रण से बाहर हो जाता/जाती हूँ।

( ) 15. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं मान लेता/लेती हूँ कि लम्बे समय तक मैं इसी तरह रहूँगा/रहूँगी।

( ) 16. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं मान लेता/लेती हूँ कि अन्ततः मैं गहरी उदासी या अवसाद का अनुभव करूंगा/करुंगी।

( ) 17. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं मानता/मानती हूँ कि

मेरी अनुभूतियॉ या भावनाएं उचित एवं महत्त्वपूर्ण हैं।

( ) 18. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मुझे अन्य चीजों पर ध्यान केन्द्रित करने में कठिनाई होती है।

( ) 19. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो लगता है मैं नियन्त्रण के बाहर हूँ।

( ) 20. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तब भी मैं कार्य कर सकता/सकती हूँ।

( ) 21. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो वैसा अनुभव करने के लिए मैं अपने आप पर शर्मिंदगी का अनुभव करता/करती हूँ।

( ) 22. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं जानता/जानती हूँ कि अच्छा या बेहतर अनुभव करने के लिए कोई न कोई एक तरीका अन्त में मैं ढूंढ ही लेता/लेती हूँ।

( ) 23. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं स्वयं को एक कमजोर व्यक्ति के रूप में देखता/देखती हूँ।

( ) 24. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं जानता हूँ कि मैं अपने व्यवहार के नियन्त्रण में रह सकता हूँ।

( ) 25. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मैं मानता/मानती हूँ कि ऐसा अनुभव करना बुरी चीज है या एक गलत बात (कृत्य) है।

( ) 26. जब मैं भावनात्मक रूप से परेशान (व्याकुल) या व्यथित रहता/रहती हूँ तो मुझे एकाग्रचित होने में

List of the five professionals for the evaluation of the Difficulties in EmotionRegulation Scale 16 (DERS-16)

S.NO.	NAME OF THE PROFESSIONAL	DESIGNATION	EXPERIENCE (IN YEARS)	AREA OF EXPERTISE
1				
2				
3				
4				
5				

Expert suggestions for modification in the Original Difficulties in Emotion RegulationScale 16 (DERS-16)

NAME OF THE PROFESSIONAL	OVERVIEW OF THE PROBLEMS FACED WHILE ADMINISTRATION OF THE ORIGINAL DERS 16	SUGGESTIONS REGARDING THE CHANGES WHICH CAN BE MADE WITH RESPECT TO ADDITION/ REMOVAL/OTHER CHANGES IN THE ITEMS

Name of the Professional _____

EVALUATION OF THE PRE-FINAL ASSESSMENT DEVICE

ITEMS IN THE MODIFIED DIFFICULTIES in EMOTION REGULATION SCALE 16	OVERALL RATING OF THE MODIFIED DERS-16 WITH RESPECT TO THE INSTRUCTIONS, ITEMS, AND OTHER ASPECTS	FURTHER SUGGESTIONS FOR IMPROVEMENT

- Rating by the professionals to be done using the Likert scale -:

1 : Extremely Unsatisfactory
2: Very unsatisfactory
3 : Neutral
4: Satisfactory
5 : Extremely Satisfactory

- The table will be modified according to the number of items kept in the pre-assessment device after expert committee evaluati

List of the five professionals for the evaluation of the Difficulties in EmotionRegulation Scale Parent Form (DERS-P)

S.NO.	NAME OF THE PROFESSIONAL	DESIGNATION	EXPERIENCE (IN YEARS)	AREA OF EXPERTISE
1				
2				
3				
4				
5				

Expert suggestions for modification in the Original Difficulties in Emotion RegulationScale 1 Parent Form (DERS-P)

NAME OF THE PROFESSIONAL	OVERVIEW OF THE PROBLEMS FACED WHILE ADMINISTRATION OF THE ORIGINAL DERS P	SUGGESTIONS REGARDING THE CHANGES WHICH CAN BE MADE WITH RESPECT TO ADDITION/ REMOVAL/OTHER CHANGES IN THE ITEMS

Name of the Professional _____

EVALUATION OF THE PRE-FINAL ASSESSMENT DEVICE

ITEMS IN THE MODIFIED DIFFICULTIES in EMOTION REGULATION SCALE Parent Form	**OVERALL RATING OF THE MODIFIED DERS-P WITH RESPECT TO THE INSTRUCTIONS, ITEMS, AND OTHER ASPECTS**	**FURTHER SUGGESTIONS FOR IMPROVEMENT**

- Rating by the professionals to be done using the Likert scale -:

1 : Extremely Unsatisfactory
2: Very unsatisfactory
3 : Neutral
4: Satisfactory
5 : Extremely Satisfactory

- The table will be modified according to the number of items kept in the pre-assessment device after expert committee evaluation